DRAFT March 6, 2013

Questions for Connecticut about the Standards & Conditions for its Proposed Managed Fee-For-Service Financial Alignment Demonstration

As discussed in the July 8, 2011 State Medicaid Director (SMD) letter that provided preliminary guidance on the financial alignment models, State demonstration proposals will be evaluated against the standards and conditions that CMS will require of all States seeking to participate in the demonstration.

CMS would like additional information from Connecticut about how its proposed demonstration would **ensure the provision and coordination of all necessary Medicare and Medicaid covered services, including primary, acute, prescription drug, behavioral health, and long-term services and supports**.

1. Please confirm that the proposed supplemental benefits that would be provided to Medicare-Medicaid beneficiaries in health neighborhoods are not current State Plan services. Are these services included in any current waivers?

   Connecticut's proposed supplemental services under Model 2 (Health Neighborhoods) are not current State Plan services and are not included in any current waivers. Supplemental services are direct services by qualified providers (such as registered dieticians, trained pharmacists, or individuals trained in statutorily-endorsed falls prevention protocols), and are not provided directly by the Lead Care Manager (LCM). Each HN will be required to describe the means by which it will provide supplemental services, including, but not limited to, the types of providers with which it will contract as well as the credentials of such providers to do so. The proposed supplemental services include the following:

   - **chronic disease self-education and management**: evidence-based practices for the chronic conditions that are most prevalent for MMEs, including, but not limited to, COPD, diabetes, and SPMI;
   - **medication therapy management**: service to 1) include medication reconciliation, medication therapy management, and medication coordination and monitoring of processes across prescribers, pharmacies and care settings; and 2) feature components including a) in-person assessment; b) development of a medication action plan to promote self-management and patient empowerment; and c) communication and collaboration with the MME's prescribers and other health care providers on evidence-based medication interventions;
   - **nutrition counseling**: counseling for individuals with chronic conditions on elements including but not limited to the interplay of diet and effective medication use, nutritional assessment to compare actual dietary intake against recommended guidelines, and education on menu planning and shopping;

- **falls prevention**: 1) services designed for community-dwelling older adults that use fall intervention approaches, including physical activity, medication assessment and reduction of medication when possible, vision enhancement and home-modification strategies; and 2) services that target new fall victims who are at a high risk for second falls and that are designed to maximize independence and quality of life for older adults, particularly those older adults with functional limitations;
- **peer support**: non-clinical interventions that support individuals with SMI and/or substance abuse issues by facilitating recovery and wellness programs by engaging trained, self-identified consumers who are in recovery from mental illness and/or substance use disorders, under the supervision of a behavioral health professional; and
- **recovery assistant**: services that include a flexible range of supportive assistance that is provided face-to-face and that enables a participant to maintain a home/apartment, encourages the use of existing natural supports, and fosters involvement in social and community activities.

2. Please provide additional information about how performance and APM II payments would be distributed among providers participating in health neighborhoods. Would the entire APM II go to the "lead" care manager, less a percentage of the total fee for administration? Would health neighborhoods be free to distribute the performance payment as they saw fit?

   Connecticut originally intended to stream both performance and APM II payments through the health neighborhoods. What has developed since submission of the original application is a shift in position as follows:

   Connecticut now proposes to make bundled APM II payments directly through the MMIS to any Lead Care Management Entity that is:

   - a participating, contracted provider in a Health Neighborhood, and;
   - employs qualified individuals that MMEs have selected to serve as MMEs' Lead Care Managers.

   The Administrative Lead Agencies at the Health Neighborhoods will be paid under an administrative contract with the Department of Social Services. They will also be eligible to participate in performance payments (see below).

   Connecticut proposes to retain its original model for performance payments.

   - In year 1 of the Demonstration, Connecticut will make performance payments to the "Administrative Lead Agency" (ALA) of each Health Neighborhood (HN) based on performance against identified measures. Connecticut will define

requirements for distribution of these payments to HN providers in its contract with each ALA.

- In years 2 and 3 of the Demonstration, Connecticut will make two types of payments to the Health Neighborhoods:
  - 1) Performance payments based on performance against quality measures
  - 2) Performance payments based on actuarially determined cost savings
  - 3 Connecticut will define requirements for distribution of both of these types of payments to HN providers in its contract with each ALA.

3. Please explain the proposed source of funding for the APM I for Medicare-Medicaid beneficiaries, and risk-adjusted APM II? Does Connecticut propose to receive federal match for those payments?

   Connecticut proposes to receive federal match for both APM I and APM II payments.

   APM I. Connecticut is currently administering a PCMH program. PCMH qualified practices receive a combination of enhanced FFS and PMPM performance incentives. Connecticut seeks to convert this program from enhanced FFS to advanced bundled payments (APMI) concurrent with implementation of the Duals Demonstration. The Department seeks to implement APM I payments and to extend the PCMH program to MMEs who participate in the Demonstration. This will be done for all qualified PCMH practices and all MMEs aligned with these practices. Connecticut seeks to receive federal match for APM I payments under Medicaid State Plan Primary Care Case Management (PCCM) [42 USC Section 1905(a) (25)] authority.

   APM II. Connecticut seeks to introduce risk-adjusted APM II payments in order to pay for care management under the Demonstration. APM II payments will be made to providers that are acting as Lead Care Managers for MMEs who are enrolled in the HNs. APM II payments will wrap around existing sources of care coordination payment in order to address the entire continuum of services to be coordinated under the Demonstration. We are currently reviewing the best means through which to pay for supplemental services. . Connecticut seeks to receive federal match for APM II payments under a hybrid of State plan Primary Care Case Management (PCCM) [42 USC Section 1905(a) (25)] and PCCM plus additional services [42 USC Section 1915(b) (3) & (4)].

4. Please provide additional information about the chronic disease self-management services that would be available to Model 2 enrollees. Would these services be provided in beneficiaries' homes or provider offices? Would they be provided on a one-on-one basis, or in groups?

   Connecticut plans through the Request for Proposals to procure HNs to provide minimum standards for providing chronic disease self-management services but also to solicit detail from

HN applicants as to how each HN proposes to implement such standards and the credentials for qualified staff. Minimum standards are expected to include 1) documentation that the strategy is evidence-based; 2) identified health conditions; and 3) applied guidelines for person-centeredness (e.g. goal setting, self-direction, teaching and training).

5. Does Connecticut propose to pursue health homes expected to involve a significant number of Medicare-Medicaid beneficiaries? If so, please explain how the health homes fit into the demonstration design for Models 1 and 2, and the expected timing of Connecticut's health home State Plan Amendment (SPA) submission.

   Connecticut has decided not to elect health home funding within the health neighborhood (HN) model that will be implemented under the duals demonstration. Instead, Connecticut plans to elect health home funding outside the context of the duals demonstration and to implement a number of condition-specific health homes for both dually-eligible and single-eligible individuals with Serious and Persistent Mental Illness (SPMI). We envision that Health Neighborhoods and Health Homes will be implemented at the same time, though are still establishing the timelines. We are planning for both programs to be implemented on or around January 1, 2014. DMHAS is currently working on the SPA and we hope to submit it in May or June of 2013.In order to successfully implement both the health neighborhood and health home models, Connecticut plans to:

   - require participation of a Behavioral Health Partner Agency (BHPA) within the structure of the health neighborhoods;
   - confirm the means by which individuals will be attributed within these models (for purposes of participation, for purposes of payment of care coordination payments) and the terms under which they can opt out;
   - confirm the terms under which providers can participate in both models;

   The Department proposes that clients eligible for both the Demonstration and Health Homes will be passively enrolled in to one of the programs, with client education about the potential to opt-out of that program and in to another, as applicable. *A client would not be enrolled in both the Demo and a BHH.* Among those who are dually eligible and have an SPMI diagnosis that qualifies them for a Health Home:

		Client has existing relationship with Behavioral Health Home (BHH) Provider?	
		No	**Yes**
Client has existing relationship with Health Neighborhood (HN) Provider?	**No**	Client is part of Demo Model 1 (enhanced ASO), with education about opt-in to BHH or HN, as applicable.	Client passively enrolled in BHH and is NOT in the Duals Demo, with education about opting in to Model 1 or HN (if geographically available)
	Yes	Client passively	Rules of attribution to the Duals

		enrolled in HN, with education about opting in to Model 1 or BHH (if geographically available)	Demonstration or BHH will be determined, and a client would receive education about other available options. (Note: This includes situations in which a BHH is also part of an HN, or when a client sees a BHH and another HN provider.)

Feature	Health Neighborhood (3-5 will be procured)	Health Home (number to be determined)
Provider composition	Broad range of medical, behavioral health, and long-term services and supports.	Care team selected from among three options identified in State Medicaid Director letter. Teams will be based at behavioral health care providers.
Population served	All Connecticut individuals who 1) are dually eligible for Medicare and Medicaid (older adults, individuals with physical disabilities, individuals with SPMI, individuals with intellectual disabilities), except those served by a Medicare Advantage plan; and 2) have received their primary care from a HN participating provider in the twelve months preceding implementation. Each HN is anticipated to serve a minimum of 5,000 individuals.	Individuals with an identified SPMI who are either eligible for Medicaid only, or eligible for Medicare and Medicaid. The population might further be limited by geography, and outreach or passive-enrollment can differ according to other population characteristics (e.g. utilization, costs).
Method of attribution	Individuals who have received their primary care (or some other types of care, as described in CT's previous application) from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN and will have the opportunity to opt out.	Individuals determined eligible for BHHs (see above) who have received their behavioral health care from a BHH provider within the twelve months preceding implementation will be auto enrolled in the BHH and will have the opportunity to opt out or choose another BHH provider.
Care coordination model	Proposes to permit participants to select a Lead Care Manager from among a list of qualified participating members of the HN.	The health home care team will provide the 6 covered HH services with the goal of integrating the beneficiary's

	This LCM will be the single point of contact for a multi-disciplinary team of providers, whose goal it is to integrate the beneficiary's medical, behavioral and long-term services and supports through a person-centered care plan. The LCM will identify and facilitate referral to appropriate supplemental services.	behavioral health, medical and community services and supports through a person-centered care plan.
Means of paying for care coordination	Connecticut proposes to make a PMPM payment that will incorporate the costs of care coordination (APM 2). We are also currently reviewing the best means through which to pay for supplemental services.	Connecticut will make a PMPM payment to the behavioral health entity in support of the costs the 6 core health home services..

CMS would like additional information from Connecticut about how its proposed demonstration would **offer mechanisms for person-centered coordination of care and include robust and meaningful mechanisms for improving care transitions (e.g., between providers and/or settings) to maximize continuity of care.**

6. Please provide additional detail about how team-based care would occur in health neighborhoods.

- Entering the Care Coordination Relationship

➢ Each HN must enter into standard care coordination agreements provided by the State of Connecticut with all member providers that detail terms including, but not limited to:

  - means of communication between MMEs, Lead Care Managers (LCMs), primary care, specialists and other providers;
  - means of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams;
  - role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

An LCM must complete a face-to-face Assessment for each MME. To complete a Demonstration Assessment, an LCM must 1) populate the standard Demonstration Assessment tool with any existing assessment results (e.g. results completed by a waiver care manager) that are not more than six months old; and either a) complete any missing elements of the Demonstration Assessment by interviewing the MME and his/her preferred representatives in person; or b) if the results of an existing assessment is more than six (6) months old or there has been an intervening

life event (e.g. serious illness, hospitalization, bereavement), complete the entire standard Demonstration Assessment tool by interviewing the MME and his/her preferred representatives in person.

- If an MME's LCM is not also serving as his or her waiver care manager, LMHA care manager, or MFP transition coordinator, the LCM shall have authority to contact and to receive assessment results from the MME's waiver care manager, LMHA care manager or MFP transition coordinator. The ICM's type and incidence of care coordination support will be informed by this level of care coordination. LCMs must ensure that care coordination provided under the Demonstration connects with, but does not supplant, other sources of care coordination support including, but not limited to, waiver care coordination, LMHA care coordination, MFP transition coordination and/or Person-Centered Medical Home (PCMH) care coordination.

- In addition to completing the Demonstration Assessment tool, the LCM must also discuss with the MME and his/her representatives and request that the MME or his/her proxy sign the 1) Demonstration Rights and Responsibilities form; 2) the Demonstration Informed Consent form; 3) the Demonstration Information Sharing form; and 4) the Demonstration Emergency Contact form. If in any case the MME declines to sign a form, the LCM shall indicate in writing that the MME has declined.

- Following completion of the Assessment, the LCM must, based on the face-to-face interview with the MME and his/her representatives and the Demonstration Assessment Tool, prepare a draft Demonstration Plan of Care (POC) that details the following: 1) the MME's goals; 2) the MME's primary presenting medical conditions, behavioral conditions, and functional limitations; 3) the MME's existing sources of care coordination support; 4) other members of the MME's Multi-Disciplinary Care Team; 5) initial level of care coordination support needed by the MME; and 6) key strategies toward meeting goals, addressing gaps in care and services, self-managing conditions and functional limitations, and anticipating and managing care transitions. The LCM must also indicate on the POC his or her recommendations for any Demonstration supplemental services that may be of benefit to the MME.

- The LCM must then share the draft Demonstration POC with the MME and his/her representatives and solicit his or her feedback for enhancements or revisions. If the MME and his/her representatives agree that the Demonstration POC reflects the MME's values and preferences, the LCM must ask the MME to sign the Demonstration POC indicating approval. If the MME and his/her representatives offer feedback for enhancements or revisions, the LCM must modify the Demonstration POC and share the revised copy with the MME and his/her representatives for signature indicating approval.

- The Demonstration Assessment and POC will be shared between relevant providers.

- <u>Levels of Care Coordination</u>

  The type and frequency of care coordination support that an LCM is providing to each MME must be informed by the level of care coordination support that the MME requires. The

requirements listed below should be considered to be a minimum set on which the HN is permitted to build.

Targeted Outreach: Targeted Outreach is a brief, focused intervention that is provided on an as-needed or situational basis. Targeted Outreach can be provided either by a Lead Care Manager or can be delegated as appropriate to an extender (e.g. care manager assistant, community health or outreach liaison). Non-exclusive examples of Targeted Outreach include 1) assistance in identifying and scheduling appointments with specialists; 2) assistance in locating and procuring transportation; 3) referrals to social services supports; and/or 4) support with general information & assistance inquiries. The LCM must document the types of Targeted Outreach that he/she is providing to the MME on the MME's Demonstration Plan of Care.

Care Management: Care Management is a periodic, intermittent support. This service must be provided by a Lead Care Manager. Non-exclusive examples of Care Management activities include 1) assessment of needs to identify unmet or underserved needs; 2) engagement with the MME and members of the MME's care team to support access to needed care, assist with chronic disease self-management, and promote medication compliance; and 3) coordinate services for planned care transitions (e.g. scheduled surgery or other acute treatment). LCMs must observe the following standards in providing Care Coordination:

Intensive Care Management: Intensive Care Management (ICM) is an ongoing support focused upon MMEs with unmet medical, behavioral health, LTSS or social support needs who are at high risk. This service must be provided by a Lead Care Manager. Examples of ICM activities include assistance in 1) assessment of needs to identify priorities; 2) engagement with the MME and members of the MME's care team to develop near term goals relating to acute/urgent care, coordination of services across the continuum of services and supports, and chronic disease self-management; 3) coordinate services for unplanned transitions; and 4) intervene with patterns of hospitalization and re-hospitalization, and/or inappropriate nursing home placement.

7. Please explain other drivers of team-based care beyond performance payments distributed by the financial lead agency of the health neighborhood?

A key driver of team-based care beyond the performance payments will be the care coordination contracts into which all provider members of the HNs will enter. These will detail terms including, but not limited to:

- best practices and standards based the experience in other states
- means of communication between MMEs, Lead Care Managers (LCMs), primary care, specialists and other providers;

- means of consultation among MMEs, LCMs and members of MMEs' multi-disciplinary care teams;
- role definitions in situations of care transition (e.g. from primary care to specialist, from specialist to secondary/tertiary specialist, from setting to setting).

8. Please explain the interaction between demonstration care managers and coordinators, and the interaction with care managers and coordinators otherwise available to Medicare-Medicaid beneficiaries, including via 1915(c) waivers.

   LCMs must coordinate contacts with the MME, his/her preferred representatives and members of the care team to identify immediate and near-term strategies in support of meeting the MME's needs. The LCM must consult with the MME and his/her preferred representatives to determine the composition of the care team most relevant to the MME's needs. Members could include a Medicaid waiver case manager, an LMHA case manager, and/or an MFP transition coordinator. However, for the MMEs participating in the Demonstration the LCM shall be the team leader and will have the final say in determining any potential conflicts or service overlaps.

9. Please provide additional information about the integration and coordination of community-based LTSS under Models 1 & 2.

   Under Model 1, the ASO will work closely with all LTSS providers in developing a Plan of Care and Care Coordination strategy for each MME.

   Under Model 2, Connecticut will require HNs to include a full complement of LTSS providers as members of their networks. LTSS case managers will participate as members of MMEs' multi-disciplinary care teams.

10. What proportion of Medicare-Medicaid beneficiaries does CT estimate would receive ICM?

    [Pending answer based on data analysis]

11. Please clarify whether Model 1 Medicare-Medicaid beneficiaries would receive in-person ICM, beyond the initial in-person needs assessment.

    Yes. Connecticut has contractually established standards for ICM in place with its medical ASO, CHN-CT. These will be adapted for purposes of the Demonstration to reflect the higher level of intensity that is anticipated to be required by MMEs. Consistent with best practices for the population, there will a focus on in-person ICM.

    In support of its ICM activity, CHN-CT has fully implemented a tailored, person-centered, goal oriented care coordination tool that includes assessment of critical presenting needs, culturally

attuned conversation scripts as well as chronic disease management scripts. This tool will be adapted under the Demonstration to tailor it to the needs of the Demonstration, consistent with the universal core assessment tool that is being developed by Connecticut in support of its State Balancing Incentive Payments Program (BIPP) efforts. Additionally, CHN-CT has in place geographically grouped teams of nurse care managers that will be expanded under the Demonstration to support MMEs.

CHN-CT will also work collaboratively with a co-located unit of Value Options (the behavioral health ASO to review hospitalizations and planned admissions to identify best strategies for MMEs' care.

12. What proportion of Medicare-Medicaid beneficiaries does CT estimate would be served by a PCMH during the demonstration period?

    [Pending completion of answer]

13. Please provide additional information about the composition and care models of PCMHs, including any modifications for Medicare-Medicaid beneficiaries.

    [Pending completion of answer]

14. Please provide additional information about the "limited medical care coordination" functions within PCMHs, and whether those functions would overlap with care coordination or ICM under Models 1 & 2.

    [Pending completion of answer]

15. Does Connecticut propose to require health neighborhoods to designate a behavioral health co-lead or partner? If so, please explain the role of that entity.

    Connecticut proposes to require HNs to identify a Behavioral Health Partner Agency (BHPA) . The roles contemplated for the BHPA are:

    Overall Structure:

    - Provide behavioral health-related leadership within the Health Neighborhood (HN)
    - Ensure that behavioral health care and the spectrum of needs and barriers among those with behavioral health conditions are properly integrated into and comprehensively addressed within the HN
    - Ensure that recovery principles and recovery-oriented systems of care are properly integrated within the HN

Care coordination:

- In partnership with the Administrative Lead Agency (ALA), develop care coordination standards and procedures and identify and disseminate best practices in care coordination and health promotion (including areas such as chronic disease self-education, preventive care) throughout the HN
- In partnership with the ALA, develop a quality improvement program for care coordination
- Be a liaison between BH providers and other medical and non-medical community service providers to promote integration and collaboration for purposes of care coordination

Data, reporting, and quality:

- In partnership with ALA, design and implement quality monitoring and improvement activities within the HN

Compliance:

- In partnership with the ALA, ensure compliance with Department's contract requirements

Training for HN Provider members:

- Identify and reach out to providers who serve the needs of those with SPMI regarding HN membership and education about the HN.
- In partnership with the ALA and the Departments, create forums for core curriculum learning collaborative activities for providers on topics including, but not limited to:
  - applied practice of person-centeredness;
  - disability culture;
  - strategies for engaging with individuals with SMI and intellectual disabilities; and
  - connecting with the range of non-medical services and supports.

- In partnership with the ALA, design and administer curriculum of educational activities for providers (such as learning collaborative sessions), to be indicated in the applicant's proposal.

Consumer Engagement:

- In partnership with the ALA, develop a comprehensive client education, outreach, and engagement program and materials (regarding the HN and care coordination, health education, etc.) .

CMS would like the following additional information from Connecticut about how its proposed demonstration would **ensure an adequate and appropriate provider network**:

16. Please provide additional information to demonstrate that provider networks, for Model 2 in particular, would be appropriate for the needs of the target demonstration population, including

sub-populations of Medicare-Medicaid beneficiaries (e.g. individuals with SPMI or I/DD, residing in institutional settings).

All MMEs, whether in Model 1 or Model 2, will have access to the full panel of Medicaid providers.

In addition, we are contemplating that each health neighborhood will be required to include membership (linked by care coordination contract) by the following:

- primary care physicians, which may include 1) independent or group internal medicine, geriatric and/or family medicine; 2) Federally Qualified Health Centers (FQHCs); and 3) hospital-affiliated outpatient clinics;
- specialists including cardiologists, endocrinologists, nephrologists, podiatrists, rheumatologists, ;
- extender staff including physician assistants and Advance Practice Registered Nurses (APRN);
- behavioral health professionals which may include 1) community mental health and substance use clinics (both private non-profit and state-operated); 2) hospital-affiliated outpatient clinics; and 3) independent practitioners;
- Access Agency(ies) for the Connecticut Home Care Program for Elders and LMHA or LMHA affiliates that serves the health neighborhood's coverage area;
- dentists;
- pharmacists;
- community-based long-term services and supports including home health agencies, homemaker-companion agencies, and adult day care centers,
- hospitals that serve the health neighborhood's coverage area;
- nursing facilities; and
- hospice providers.

It is desirable but not required for each health neighborhood to include membership by the following:

- Durable Medical Equipment (DME) providers;
- Emergency Response System (ERS) providers;
- hearing aid providers;
- opthalmologists.

The incidence of required providers relative to the number of participating MMEs is TBD.

Each health neighborhood will also be required to include membership by the following **information & assistance affiliates**:

- Infoline;

- the CHOICES program that serves the health neighborhood's coverage area; and
- the Aging & Disability Resource Center that serves the health neighborhood's coverage area.

Information & assistance affiliates may participate in care coordination, but are not permitted to serve as Lead Care Managers (LCM) or to receive APMII or performance payments.

It is desirable but not required for each health neighborhood to include membership by **social services affiliates**. Social services affiliates are defined as including services and supports of a non-medical nature that are of value in addressing the whole person needs of MMEs. Non-exclusive examples of these include housing organizations, home renovation/accessibility contractors, bill payment/budgeting services, and employment services.

Social services affiliates may participate in care coordination, but are not permitted to serve as Lead Care Managers (LCM) or to receive APMII or performance payments.

Health Neighborhoods will also be expected to coordinate with relevant ASOs (CHN-CT for medical, ValueOptions for behavioral health, Benecare for dental, LogistiCare for transportation) in order to facilitate clients' access to services.

17. Please clarify the meaning of "provider transmittals" (p. 34) that would help promote provider participation in health neighborhoods.

    DSS regularly issues provider transmittals (notices) to Medicaid performing providers to detail changes in covered services, revisions to prior authorization requirements, updates rate schedules and provider obligations. Provider transmittals are issued in writing and electronically, and are posted to a central "HUSKY" web site:

    http://www.huskyhealthct.org/providers.html?hhNav=|

    In that this is a well-recognized means of communicating with providers, Connecticut proposes to include this resource as one of many means of engaging providers in the process of forming health neighborhoods. Other means include provider forums, technical assistance support through a contractor, and Q&A documents.

CMS would like additional information from Connecticut about how the proposed demonstration would address the following issues related to **beneficiary protections**:

18. Please clarify whether Medicare-Medicaid beneficiaries eligible for enrollment with a health neighborhood would have the opportunity to opt out of the health neighborhood and into the ASO-only Model 1 in advance.

Yes. During an open enrollment period, MMEs will have the right to opt out of HN participation and participate in Model 1 in advance of when enrollment would become effective.

The State of Connecticut plans to use the following means of affiliating MMEs with HNs:

MMEs who have received their primary care or behavioral health care from an HN participating provider within the twelve months preceding implementation of the Demonstration will be passively enrolled with that HN under Model 2. The Department proposes to use a "step-wise" enrollment process under which the ASO will:

- first consider whether the individual has received care from a primary care provider (including a primary care physician, FQHC, clinic, or geriatrician), and if so, enroll on that basis;
- if not, next consider whether the individual has received care from a behavioral health care provider (including psychiatrist, psychologist or licensed clinical social worker), and if so, enroll on that basis; and if not, next consider whether the individual has received care from a specialist (including, but not limited to, a cardiologist or a nephrologist) for one or more chronic conditions, and if so, enroll on that basis.

A neutral enrollment broker will have primary responsibility for issuing initial notices and welcome packets to each MME who is passively enrolled in an HN. The notice will disclose:

- the benefits of participation, including, but not limited to, access to care coordination and supplemental services;
- the nature of information sharing that will occur;
- the nature of any shared savings agreement in which the HN is participating; and
- the right to opt out of participation in the HN.

The welcome packet will include a list of provide members of the HN, a list of qualified Lead Care Managers (LCMs), a description of the supplemental services that will be provided and a list of the providers that will supply them, a form identifying the MME's preferred LCM, a form documenting the MME's rights and responsibilities, and a form permitting the MME to opt out of participation in the Demonstration.

19. What protections would be in place for a Model 2 enrollee who is dissatisfied with a Lead Care Manager, and wishes to select a new Lead Care Manager?

    On a monthly basis, Connecticut will permit MMEs to select another LCM within the Health Neighborhood in the event that they are dissatisfied with the level of service provided.

CMS also asks Connecticut to provide the following information about how its proposed demonstration would meet the **implementation** standard:

20. Has Connecticut learned any lessons from the last year of State FFS-oriented reform that would inform the design and/or implementation of a Managed FFS demonstration?

    Connecticut has gained experience from the Intensive Care Management (ICM) model that is operated by the ASO (the Community Health Network). These services are targeted to individuals identified based on system analytics as high risk individuals with chronic disease. The service is not limited to MMEs. Some lessons learned in relation to ICM include the challenges of cold contacting clients for ICM, the challenges presented by incorrect contact information, the value of in-person contact, and the need for behavioral health collaboration in addressing emergency department usage.

    Both Models will work to further address the latter two lessons. HNs will be able to leverage providers' existing relationships with clients in order to address the former two lessons and facilitate ICM.

    [Additional components of answer are pending]

21. When does Connecticut expect to transition from making enhanced FFS payments to advanced payments to PCMHs? When does Connecticut plan to submit the relevant State Plan Amendment(s)?

    Connecticut seeks to introduce risk-adjusted APM I payments contemporaneous with implementing the Demonstration. Connecticut plans to submit the relevant SPAs as soon as it has entered into a Demonstration MOU with CMS.

22. What is the minimum number of participating health neighborhoods that Connecticut would require to implement Model 2?

    Connecticut anticipates a minimum of three qualified HNs to implement Model 2.

23. What is the current timeline for Connecticut to procure health neighborhoods?

    Contingent upon the timing of an MOU with CMS, Connecticut intends to procure HNs in Fall, 2013.